

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
Life
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
837 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 837 West Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Alta Cushwa Ardinger

3.(b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife George L. Ardinger
 7. Birth date of deceased (mo., day, yr.) August 16, 1881 6.(c) If alive, give age, years
 8. AGE: Years 67 Months 1 Days 24 If less than one day
 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business
 12. Name Frederick Semler
 13. Birthplace Germany
 14. Maiden name
 15. Birthplace Germany

16. Informant Charles A. Ardinger
 Address Hagerstown, Maryland
 17. Burial Date thereof 10-13-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Oct. 12, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

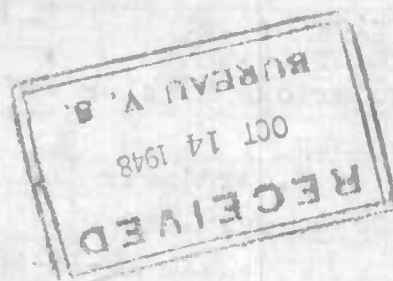
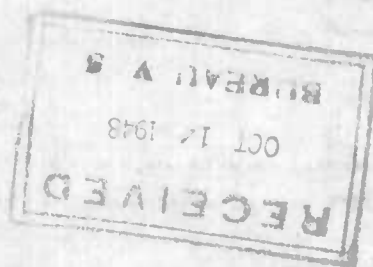
20. DATE OF DEATH Oct 11-48 at 4:20 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8-48 to Oct 11-48
 and that I last saw her alive on Oct 10-48 19

Immediate cause of death
Cerebral Hemorrhage
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
 Address [Signature] Date signed 10-14-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr/ Earl Young

552x

10789

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Years
 Hospital, institution, or street address where death occurred:
120 Alexander St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 120 Alexander St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

JAMES HOWARD BAGLEY

3. (b) Social Security Number

217-10-6925

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Vista white
 7. Birth date of deceased (mo., day, yr.) September 27 1900
 8. AGE: Years 48 Months 0 Days 26 If less than one day hrs. min.
 8. (c) If alive, give age 45 years

9. Birthplace Bedford Valley Pa.
 (Town, county, and state)

10. Usual occupation Chef.

11. Industry or business Savoy Restaurant

12. Name James H. Bagley

13. Birthplace Bedford Valley Pa.

14. Maiden name Etta Drening

15. Birthplace Bedford Valley Pa.

16. Informant Mrs. Vista Bagley

Address Hagerstown Md.

17. Burial Date thereof 10/26/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Thomas cemetery

Location Bedford Pa.

18. Funeral director George Funeral Home

Address Cumberland Md

19. Oct. 25, 1948 Chas. H. Rivers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1948 19 at 10:23:48 im

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-48 19 to 10-23-48 19

and that I last saw him alive on 10-23-48 19

Immediate cause of death Visual Carcinoma

DURATION

8 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Whom did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Young M. D. or other

Address Hagerstown Md Date signed 10/25/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10790

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport RFD #1
(If outside city or town limits, write RURAL and give nearest town)Street No. Williamsport RFD #1
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Pamela Kay Baker

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1948 6.(c) If alive, give age years8. AGE: Years 0 Months 0 Days 1 If less than one day 21 hrs. 26 min.9. Birthplace Hagerstown, Wash., Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Charles Roger Baker13. Birthplace Grimes Station, Maryland14. Maiden name Hilda Louise Yeakle15. Birthplace Big Spring, Maryland16. Informant Mr. Charles R. BakerAddress Williamsport, Md. RFD #117. Burial November 1, 1948
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory St. Pauls CemeteryLocation Near Clearspring, Md.18. Funeral director Mrs. Edith V. LeafAddress Williamsport, Md.19. Nov. 1, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, at 3:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29, 1948 to Oct. 31, 1948
and that I last saw her alive on October 30, 1948Immediate cause of death Perinatal Mortality
(GESTATION 7 MONS.)

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

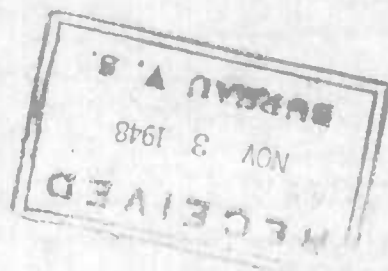
Means of injury Injured at work?

23. SIGNATURE Paula Robert Cohen M. D. or otherAddress Clear Spring Md. Date signed 11-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In street age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10791

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington County
 City or town St. James
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
St. James Rural
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town St. James
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Marlin Gene Brown

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) August 13, 1948 8. (c) If alive, give age _____ years
 8. AGE: Years 0 Month 2 Days 1 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1948 at 7:30 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Oct 1948 to 14 Oct 1948
 and that I last saw him alive on 12 Oct 1948
 Immediate cause of death bronchitis pneumonia
 DURATION 2 days

9. Birthplace Hagerstown, Washington, Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Charles H. Brown
 13. Birthplace Maryland
 14. Maiden name Mary Damer Brown
 15. Birthplace Maryland

16. Informant Mr. Charles H. Brown
 Address St. James Maryland

17. Burial Date thereof Oct. 16, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland

19. Oct 16 1948 John H. Baer
 (Date rec'd by registrar) Registrar

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Eldon G. H. Vail
 Address Hagerstown Md Date signed 15 Oct 48
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bell

10792

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
649 Potomac Ave
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 649 Potomac Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

MRS BLANCH MARTIN BEARD BURGER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Edward L.
 6. (c) If alive, give age 76 years
 7. Birth date of deceased (mo., day, yr.) October 6 1873
 8. AGE: Years 75 Months 0 Days 8 If less than one day
hrs. min.

9. Birthplace Chewsville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
Own Home
 11. Industry or business
 12. Name Silas Beard
 13. Birthplace Smithsburg Md.
 14. Maiden name Clara Martin
 15. Birthplace Smithsburg Md.

16. Informant Edward L. Burger
 Address Hagerstown Md.

17. Burial Date thereof 10/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct. 26 19 48 Chas H. Rowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 18, 1948 to Oct 24, 1948
 and that I last saw him alive on October 23, 1948

Immediate cause of death Cerebral hemorrhage DURATION 6 days

Due to

Due to

Other condition Arteriosclerosis & Hypertension
 (Include pregnancy within 3 months of death)

Major findings of operations No operations Date of op.

Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Ra Bee M. D. overlaid
 Address Hagerstown, Md. Date signed 10/25/48

RECEIVED
OCT 28 1948
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells 10793

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1016 Pope Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS EFFIE PEARL BURKE

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife William
 6.(c) If alive, give age 50 years
 7. Birth date of deceased (mo., day, yr.) February 12 1896
 8. AGE: Years 52 Months 8 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace No Record
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name No Record
 13. Birthplace No Record
 14. Maiden name No Record
 15. Birthplace No Record

16. Informant George Hicks
 Address Hagerstown Md.
 17. Burial Date thereof 10/20/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. Oct. 19, 48 Charles H. Brewer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 18 1948 at 4 / 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 18 1948
 and that I last saw her alive on Oct 18 1948

Immediate cause of death Vascular Hypertension
 Due to auricular fibrillation
chr. glomerular nephritis
 Due to acute cerebral embolus 24hrs
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. _____
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide no Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE S. Robert Wells, M.D.
 M. D. Wagerstown, Md.
 Date signed 10/19/48

RECEIVED

OCT 21 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 yrs.
 Hospital, institution, or street address where death occurred:
Washington St, Hancock, Md
 How long in hospital or institution —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

Albert Creamer Carr

3. (b) Social Security Number

232-26-7986

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Meda M^Y Laughlin Carr
 6.(c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) Mar. 28, 1883
 8. AGE: Years 65 Months 6 Days 5 If less than one day — hrs. — min.

9. Birthplace Warfordsburg, Fulton Co., Penna.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business —

FATHER 12. Name Charles Carr

13. Birthplace Washington Co., Md.

MOTHER 14. Maiden name Abigail Truax

15. Birthplace Fulton Co., Penna.

16. Informant Mrs Meda Carr

Address Hancock, Md.

17. Burial Date thereof Oct 6, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Thomas Episcopal

Location Hancock, Md.

19. Funeral director Charles R. Bast

Address Hancock, Md.

19. Oct 6, 1948 Registrar J. H. Feller

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3, 1948 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1947 to 10/3/48 19. 1948
 and that I last saw him alive on 10/2/48 19. 1948

Immediate cause of death Cod liver
decompensation

DURATION 5 yrs
 Due to Myocarditis

Due to —

Other conditions —

(Includes pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — injured at work? —

23. SIGNATURE J. H. Feller MD

M. D. or other —

Address Hancock, Md. Date signed 10/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Beachley 10795

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Years
 Hospital, institution, or street address where death occurred:
1332 Fairchild Ave
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1332 Fairchild Ave
 (If rural, give LOCATION)
None
 2. (a) If veteran, name war None

3. (a) FULL NAME

CHARLES PHILO CHIDESTER

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Naomi
 6. (c) If alive, give age -- years
 7. Birth date of deceased (mo., day, yr.) May 27 1862
 8. AGE: Years 86 Months 4 Days 18 If less than one day hrs. min.

9. Birthplace Canfield Mahoney Co. Ohio
 (Town, county, and state)
 10. Usual occupation Custodian of High School
Retired
 11. Industry or business
 12. Name Royal Chidester
 13. Birthplace Canfield Ohio
No Record
 14. Maiden name
 15. Birthplace No Record

16. Informant Curtis P. Chidester
 Address Hagerstown Md.
 17. Removal Date thereof 10/19/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Canfield Cemetery
Canfield Ohio
 Location
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md

19. Oct. 16 19 48 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 12 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 48 to Oct 15 48

and that I last saw him live on Oct 15 48

Immediate cause of death General Thrombosis
Arterio Sclerosis

Due to Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. Beachley M.D.
Hagerstown, Md. M.D. or other
 Address Hagerstown, Md. Date signed Oct. 16 48

RECEIVED
OCT 19 1943
BUREAU F. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10796 3021

1. PLACE OF DEATH:

County WASHINGTON
 City or town HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 YRS.
 Hospital, institution, or street address where death occurred:
321 BROOKLINE AVE.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON
 City or town HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 321 BROOKLINE AVE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war NON-VET

3. (a) FULL NAME

MARGARET ELIZABETH

3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife ERNEST A. CLEVINGER6.(c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) AUGUST 26, 1902

8. AGE: Years 46 Months 1 Days 23 If less than one day
 hrs. min.

9. Birthplace EMMITSBURG, FREDERICK, MD.
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name LUTHER M. ZIMMERMAN13. Birthplace EMMITSBURG, MARYLAND14. Maiden name EDNA WAESCHE15. Birthplace THURMONT, MARYLAND16. Informant ERNEST A. CLEVINGERAddress 321 BROOKLINE AVE, HAG. MD.17. BURIAL Date thereof 10/22/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory MT. HEBRONLocation WINCHESTER, FREDERICK CO., VA.18. Funeral director W. T. NORMENTAddress HAGERSTOWN, MD.19. Oct 20 19 48 Shasth Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 19 48 at 11:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 47, to Oct 19 48and that I last saw her alive on Oct 19 19 48Immediate cause of death metastaticcarcinoma

DURATION

1 yrDue to Primary site: BreastDue to 11/20/48

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Vh Campbell M.D.Address Hagerstown Date signed 10/20/48

RECEIVED

OCT 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10797

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two Weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital
Two Weeks

How long in hospital or institution? Two Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Downsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Russel Cline

3. (b) Social Security Number

215-09-7363

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 24, 1902

8. AGE: Years 46 Months 6 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Downsville, Wash., Maryland
(Town, county, and state)

10. Usual occupation Dye Room Laborer

11. Industry or business Byron's Tannery

12. Name John Clayton Cline

13. Birthplace Fredrick County, Maryland

14. Maiden name Florence Wolford

15. Birthplace Near Downsville, Md.

16. Informant Mrs. Percy Murray

Address Williamsport, Maryland.

17. Burial Date thereof October 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Manor Cemetery

Location Near Tilghmanton, Maryland

18. Funeral director Mrs. Edith V. Leaf

Address Williamsport, Maryland.

19. Oct. 11. 19 48 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 19 48, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 19 48 to Oct 10 19 48

and that I last saw him alive on Oct 9 19 48

Immediate cause of death uraemia DURATION 2 weeks

Due to Cardio-vascular Renal disease ?

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE N. L. Porterfield M.D. M. D. or other _____

Address 136 W Washington Date signed 10/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr/ Wells

1700

10798

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Hours
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 6 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Mill St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

JOHN SAMUEL CRILLY

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife... Carrie
 6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) September 22 1907

8. AGE: Years 41 Months 1 Days 3 If less than one day
 hrs. min.

9. Birthplace... Clearspring Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business

12. Name... John Crilly

13. Birthplace... Virginia

14. Maiden name... Susan Cok

15. Birthplace... clearspring Md.

16. Informant... William Henson

Address... Hagerstown Md.

17. Burial Date thereof... 10/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Green Hill cemetery

Location... Williamsport Md.

18. Funeral director... Andrew K. Coffman

Address... Hagerstown Md.

19. Oct 28 19 48 Charles Howard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... October 25 1948 at 10.30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 ... 19 ... to ... 19 ...
 and that I last saw him ... alive on ... 19 ...

Immediate cause of death... Multiple open fractures
of pelvic bones

Due to... rupture of intestines
hemorrhage and shock

Due to...
 Other conditions...

(Include pregnancy within 3 months of death)

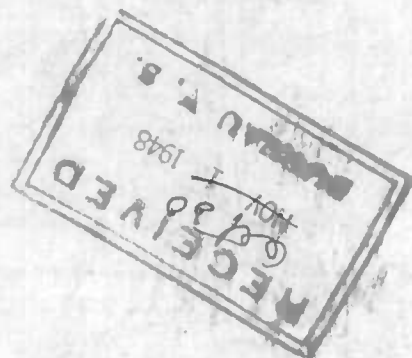
Major findings of operations... as above
 Date of op. ...

Autopsy results... no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Accident Date of... 10/25/48
 Where did injury occur? Hagerstown, Wash. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Highway - Chagrin Ave
 Means of injury Fell under truck at work? No

DEPUTY MEDICAL EXAM.
S. Robert Wells WASH. CO., MD.
 M. D. Wells

23. SIGNATURE... Charles Howard
 Address... Hagerstown, Md. Date signed 10/27/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10799

306

1. PLACE OF DEATH:

County Washington
City or town Cascado
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 4 days
Hospital, institution, or street address where death occurred:
Ritchie Hosp.
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 4th P. Oliver Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war ☒

3. (a) FULL NAME

David John Davies

3. (b) Social Security Number

233-09-3080 A

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Louella M. Peep

7. Birth date of deceased (mo., day, yr.) Oct 18, 1866 6. (c) If alive, give age 78 years

8. AGE: Years 81 Months 11 Days 18 It less than one day hrs. min.

9. Birthplace South Wales
(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business Caddren

12. Name Thomas W. Davies

13. Birthplace S. Wales

14. Maiden name Ann Janin

15. Birthplace S. Wales

16. Informant Hosp. records

Address Removal Date thereof 10/8/48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Fairmount

Location Hamden Jackson Co. Ohio

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 19 48 at 305P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 48 to Oct 6 19 48

and that I last saw him alive on Oct 6 19 48

Immediate cause of death peripheral circulatory failure DURATION 3 days

Due to arteriosclerosis ?

Due to chronic dermatitis 1 yr.

Due to seven

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Armstrong, M.D.
Address Ritchie Hosp. Md. Date signed 10/6/48

19. 10/8 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
328 Mitchell Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 328 Mitchell Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Anna E. Davis

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Thomas B. Davis

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 9, 1857

8. AGE:

Years

Months

Days

If less than one day

91

2

22

hrs.

min.

9. Birthplace

Newton Hamilton

Pa.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own Home

FATHER

12. Name
13. Birthplace

John Culbertson

Newton Hamilton Pa.

MOTHER

14. Maiden name
15. Birthplace

Mary Jane Morrisin

Newton Hamilton Pa.

16. Informant

Address

Mrs. C.E. Magruder

Hagerstown Md.

17.

Burial

Date thereof October 3, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Address

SCOTT F. MINNICH & SON
HAGERSTOWN MD

19.

(Date rec'd by registrar)

19. 48

Oct 2, 1948
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948 at 6:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 - 1948 to Oct 1 - 1948
and that I last saw her alive on Oct 1 - 48 19.

Immediate cause of death

DURATION

Cardio-Vascular Disease6 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

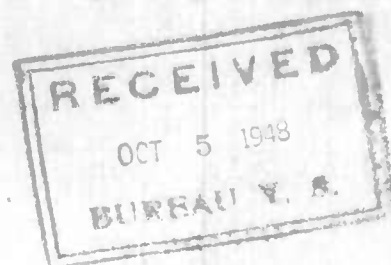
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Dr. Cohen 10801

Reg. Dist. No. 301

1. PLACE OF DEATH:

County... Washington
City or town... Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
S. Potomac St.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Washington
City or town... Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. S. Potomac St.
(If rural, give LOCATION)
None
2. (a) If veteran, name war None

3. (a) FULL NAME

WILLIAM THOMAS DURBORAW

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
B. (b) Name of husband or wife Elsie Rice
B. (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) June 19 1874
8. AGE: Years 74 Months 4 Days 5 If less than one day hrs. min.

9. Birthplace McCoys Ferry Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Lock Tender Canal
11. Industry or business Retired

MOTHER FATHER
12. Name Thomas Durboraw
13. Birthplace McCoys Ferry Md.
14. Maiden name Mary Moore
15. Birthplace McCoys Ferry Md.

16. Informant Raymond M. Durboraw
Address Williamsport Md.

17. Burial Date thereof 10/26/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill cemetery
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. Oct. 25, 48 E. Lee Mc Elroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 19 48 at 9.10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 19 43 to Oct 24 19 48
and that I last saw him alive on October 21 19 48

Immediate cause of death Carcinoma Stomach DURATION 8

Due to Peptic ulcer 30 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

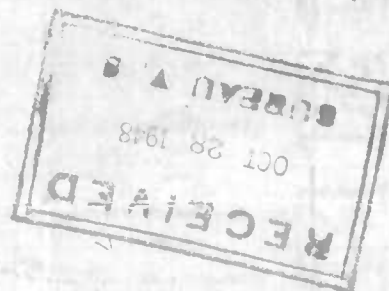
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur Robert Cohen M. D. or other
Clear Spring, Md. Date signed 10-25-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10802

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
68 Wayside Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 68 Wayside Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3.(a) FULL NAME

Mary Elizabeth Dutrow

3.(b) Social Security Number

NONE

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	---------------------------------------------------------------

6.(b) Name of husband or wife Edward M. Dutrow
 6.(c) If alive, give age 80 years
 7. Birth date of deceased (mo., day, yr.) February 4, 1879
 8. AGE: Years 69 Months 8 Days 21 If less than one day
 hrs. min.

9. Birthplace Middletown, Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Charles H. Derr
 13. Birthplace Middletown, Maryland
 14. Maiden name Mary C. Neikirk
 15. Birthplace Middletown, Maryland

16. Informant Edward M. Dutrow
 Address Hagerstown, Maryland
 17. Burial Date thereof 10-28-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lutheran Cemetery
 Location Middletown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland
 19. Oct. 27, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948 at 6:35 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 1948 to October 25, 1948
 and that I last saw him alive on October 25, 1948
 Immediate cause of death Cancer of liver
 DURATION 3 mos
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op.
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide none Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE [Signature] M. D. or other
Hagerstown Md Address Date signed 10/26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

10803

1. PLACE OF DEATH:

County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
23 N. Conococheague St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town RURAL-Taylor's Landing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sharpsburg, Md. RFD# 1
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Meta Bowser Earnshaw

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Frank Earnshaw
6. (c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) July 6, 1881
8. AGE: Years 67 Months 2 Days 28 If less than one day
hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948, at 12:30 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Oct 5 1948
and that I last saw him alive on Oct. 5 1948
Immediate cause of death

DURATION

Funeral home
Due to 7 bones
Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE

W. J. M. E. H.
Address Williamsport Date signed Oct. 6/48

9. Birthplace Williamsport, Wash., Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
12. Name William Bowser
13. Birthplace Williamsport, Md.
14. Maiden name Hannah Ardinger
15. Birthplace Williamsport, Md.
16. Informant Miss Katherine Bowser
Address Williamsport, Md.
17. Burial Date thereof Oct. 6, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Riverview Cemetery
Location Williamsport, Md.
18. Funeral director Edith V. Leaf
Address Williamsport, Md.
19. Oct 6 1948 E. Lee McElroy
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Layman

10804

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yearsHospital, institution, or direct address where death occurred:
119 Winter St.How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 Winter St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

CHARLES HOWARD FITEZ

3. (b) Social Security Number

705-10-4730

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Esta Stitely7. Birth date of deceased (mo., day, yr.) June 22 18868. AGE: Years Months Days If less than one day
62 3 22 --- hr. --- min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation Car Man11. Industry or business N. M. R. R.12. Name John Fitez13. Birthplace Westminster Md14. Maiden name Amanda Whitmore15. Birthplace Westminster Md.16. Informant Mrs. Esta FitezAddress Hagerstown Md.17. Burial Date thereof 10/17/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Blue Ridge CemeteryLocation Thurmont Md.18. Funeral director M. L. Greager And SonAddressee Thurmont Md.19. Oct. 15, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948 at 5 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 a.m. 1948 to 1900 1948 and that I last saw him alive on 13 October 1948Immediate cause of death Lues, Central Nervous SystemDue to Sporadic Bacteria DURATION 3 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Layman, M.D. M. D. or otherAddress Hagerstown, Md Date signed 10-19-48

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

RECEIVED
OCT 18 1968
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10805

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 years
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1100 Hamilton Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Edward Fry

3. (b) Social Security Number

215-20-7577

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Exie M. Fry
6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 9, 1874

8. AGE: Years 74 Months 6 Days 20 (1 less than one day) hrs. min.

9. Birthplace Knoxville Frederick Co. Md.
(Town, county, and state)

10. Usual occupation Real Estate

11. Industry or business Self Employed

12. Name Charles W. Fry
13. Birthplace Loudon Co. Va.

14. Maiden name Mary M. Goodman
15. Birthplace Petersville Fred. Co. Md.

16. Informant Mrs. Exie M. Fry
Address Hagerstown Md.

17. Burial Date thereof Nov. 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Luthern Cemetery
Location Boonesboro Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. Oct 31, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 29 1948
and that I last saw him alive on 29 Oct 1948

Immediate cause of death Carcinoma of Colon with metastasis Perforation of colon

Due to _____

Due to _____

Other conditions Epithelioma face

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Peritonitis due to above
Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert V. H. Campbell MD
M. D. or other _____

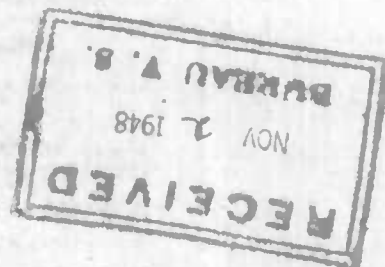
Address Hagerstown Md Date signed 10/30/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

10806

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? --

Hospital, institution, or street address where death occurred:

613 N. Mulberry St.How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 613 N. Mulberry St.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Mrs. Leola Gelwicks

3. (b) Social Security Number

219-05-28934. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Charles Gelwicks7. Birth data of deceased (mo., day, yr.) May 6, 1912 8. (c) If alive, give age 36 years8. AGE: Years 36 Months 5 Days 3 If less than one day hrs. min.9. Birthplace Hagerstown, Md.
(Town, county, and state)10. Usual occupation Waitress11. Industry or business Waitress12. Name Charles Gelwicks13. Birthplace Hagerstown, Md.14. Maiden name Nettie Smith15. Birthplace Rohrersville, Md.16. Informant Mrs. Charles GelwicksAddress 613 N. Mulberry St.17. Burial Date thereof Oct. 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.19. Oct. 11, 1948 Registrar Phasf Flowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948 at 1:30 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec/17/47 1947 to Oct/8/48 1948and that I last saw her alive on Oct/8/48 1948Immediate cause of death carcinoma of uterus DURATION 16 mos.Due to profuse hemorrhage 12 hrs.Due to profuse hemorrhage 12 hrs.Other conditions profuse hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. NoneAutopsy results None PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Dr. Robert Wells, M.D. M. D. o. NoneAddress Hagerstown, Md. Date signed 10/11/48

RECEIVED
OCT 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Smithsburg Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Smithsburg Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) if veteran, name war.....

3. (a) FULL NAME

Elsie Burely Satty

3. (b) Social Security Number

none

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband..... J. Walter Satty 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Sept. 14 - 1873

8. AGE: Years..... 75 Months..... 1 Days..... 1 if less than one day..... hrs. min.

9. Birthplace..... Frederick, Md.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... P. H. C. Burely

13. Birthplace..... Maryland

14. Maiden name..... Margaret Ellen Beile

15. Birthplace..... Maryland

16. Informant..... Mrs. Edna J. Smith

Address..... Smithsburg R. H. Rd.

17. Burial, cremation, or removal, Which..... Burial Date thereof..... 10/18/48
 (month) (day) (year)

Cemetery or crematory..... mt. Olivet Cemetery

Location..... Frederick, Md.

18. Funeral director..... Chas. W. Hartner & Sons

Address..... Cheson Bridge & New Windsor, Md.

19. Date rec'd by registrar..... Oct 17 1948 Registrar..... Geo. W. Ferguson

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 15 1948 at 11:55 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 May 1948 to 15 Oct 1948
 and that I last saw her alive on 15 Oct 1948

Immediate cause of death..... Carcinoma (Schimmus) rt. Breast DURATION..... 6 mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma of Breast

Date of op..... 20 Jun 48

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... J. F. Lusk M. D. or other.....

Address..... 230 N. Potomac Date signed..... 16 Oct 48

RECEIVED

OCT 22 1948

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10808 306

1. PLACE OF DEATH:

County Washington
 City or town Cascade
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos + days

Hospital, institution, or street address where death occurred:

Ritchey HospitalHow long in hospital or institution? Same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt #1
(If rural, give LOCATION)2. (a) If veteran, name war Subsistence

3. (a) FULL NAME

John Henry Golliday

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Ruth (divorced)

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 16 18858. AGE: Years 63 Months 7 Days 9 If less than one day..... hrs. min.9. Birthplace Rt #1, Mt. Jackson, Va.
(Town, county, and state)10. Usual occupation Subsistence

11. Industry or business

12. Name Henry Golliday13. Birthplace Mt. Jackson, Va.14. Maiden name F. G.15. Birthplace Mt. Jackson, Va.16. Informant Hosp. records

Address

17. Burial Date thereof 10/28/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory U.B. CemeteryLocation Hampton, Va.18. Funeral director H. K. HoffmanAddress Washington Md.19. 10/25/48 19.....
(Date rec'd by registrar) John P. ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 19 48 at 2:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 15 19 48 to Oct 25 19 48and that I last saw him alive on Oct 24 19 48

Immediate cause of death

Carcinomatous primary site undetermined

DURATION

3 yrs +

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

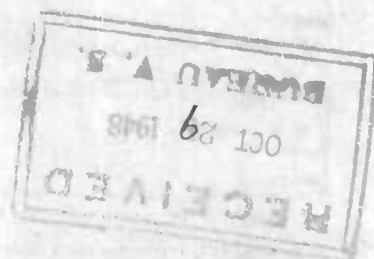
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. M. Amington, M.D.
M. D. or otherAddress Ritchey Hosp. Date signed 10/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10809 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 weeks
 Hospital, institution, or street address where death occurred:
7 Lincoln Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County Berkley
 City or town Shepherdstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elmer L. Gordon

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1869

8. AGE: Years 79 Months 0 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick County
 (Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business _____

FATHER 12. Name Joseph L. Gordon13. Birthplace VirginiaMOTHER 14. Maiden name Mary Delauter15. Birthplace Myersville, Md16. Informant Mr. Earl M. GordonAddress Frederick, Maryland

17. Burial Date thereof Oct. 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium BrownsvilleLocation Brownsville, Md18. Funeral director R. I. EarnshawAddress Keedysville, Md

19. Oct 27 19 48 Booth Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 19 48, at 8:50 P. M.21. I CERTIFY that death occurred on the date above stated; that it attended deceased from Oct 23-48 19, to Oct 26-48 19,and that I last saw him alive on Oct 26-48 19.

Immediate cause of death _____ DURATION

Ischemic Heart Disease 3 yrs
 Due to _____

Coronary Artery Disease 6 yrs
 Due to _____

Arteriosclerosis 6 yrs
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE EW [Signature] M. D. or otherAddress [Signature] Date signed 10/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Reg. Dist. No. 10810 306

1. PLACE OF DEATH:

County Washington
City or town Highfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County Washington
City or town Highfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

John Wickiuff Hackett

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.
6. (b) Name of husband or wife Sally B. Branch
6. (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) Jan 26, 1869
8. AGE: Years 79 Months 8 Days 20 hrs. _____ min. _____
8. AGE: Years _____ Months _____ Days _____ It less than one day _____

9. Birthplace Buckingham Co., Va.
(Town, county, and state)
10. Usual occupation mail carrier
11. Industry or business _____
12. Name J. P. Hackett
13. Birthplace Buckingham Co., Va.
14. Maiden name Sarah Eliza Stark
15. Birthplace Buckingham Co., Va.

16. Informant Mrs. Sally Hackett
Address Highfield Md.
17. Burial Date thereof 10/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bethel
Location Md.

18. Funeral director Walter Y. Grove
Address 27 S. Church St., Waynesboro Pa
19. Oct 18 19 48 W. H. Ferguson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 October 19 48 at 8:15 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 October 19 48 to 16 October 19 48 and that I last saw him 15 October 19 48 alive on _____
Immediate cause of death Coronary Occlusio
Due to Arteriosclerosis laches
Due to vas wall thromb
Other conditions Old Age
(Include pregnancy within 3 months of death)

DURATION

3 days

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Ferguson M.D.
Address Blue Ridge Summit Date signed 16 Oct 48
M.D. or other _____

RECEIVED

OCT 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

61

10811

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town Mapleville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, institution, or street address where death occurred:
Main St.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 318 No. Prospect st.
(If rural, give LOCATION)
None
2.(a) If veteran, name war None

3. (a) FULL NAME

MRS LUCY ANN FAULDERS HANCOCK

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Charles Edw.

7. Birth data of deceased (mo., day, yr.) August 2 1875 6. (c) If alive, give age -- years

8. AGE: Years 73 Months 2 Days 14 If less than one day
.....hrs.min.

9. Birthplace Mt. Lena Wash. Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name John Faulders

13. Birthplace Mt. Lena Md.

MOTHER 14. Maiden name Rachael Cox

15. Birthplace Mt. Lena Md.

16. Informant Mrs. Chester Semler

Address Hagerstown Md.

17. Burial Date thereof 10/18/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct. 16. 1948 John H. Bax
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1948 at 12:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1941 to Oct 16 1948
and that I last saw her alive on Oct 6 1948

Immediate cause of death Diabetes M

Due to Vascular hypertension

coronary arteriosclerotic

heart disease

Due to acute coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells M.D.

M. D. or other

Address Hagerstown, Md. Date signed 10/16/48

RECEIVED

OCT 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Cohen

10812

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penna. County Fulton
 City or town Rural Warfordsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. --
 (If rural, give LOCATION)
 2. (a) If veteran, name war None ✓

3. (a) FULL NAME

JOB HESS

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bell Morgret
 6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) April 22 1869

8. AGE: Years 79 Months 6 Days 3 If less than one day hrs. min.

9. Birthplace McConelsburg Fulton Co. Pa.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business --

12. Name Aaron Hess

13. Birthplace Fulton Co. Pa.

14. Maiden name Anna Garland

15. Birthplace Fulton Co. Pa.

16. Informant Mrs. Denver Evans

Address Warfordsburg Pa.

17. Burial Date thereof 10/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Grove Cemetery

Location Fulton Co. Pa.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct. 26 48 Chas. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948 at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 19 48 to Oct. 25 19 48
 and that I last saw him alive on October 25 19 48

Immediate cause of death Coronary occlusion
Coronary occlusion
 Due to Atherosclerotic hyper
tensive cardiac disease
 DURATION 1 day
19 days
?

Other conditions Thrombotic-type
undetermined
 (Include pregnancy within 3 months of death)

Major findings of operations None.

Autopsy results none. Date of op. None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Audie Robert Cohen
 Address Clear Spring Md. M. D. 10-26-48

Date signed 10-26-48

RECEIVED
OCT 28 1946
BUREAU 4-8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 307

10813

1. PLACE OF DEATH

County Washington
City or town Yarrowsburg Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4.5 yearsHospital, institution, or street address where death occurred:
Knoxville Md. R.1How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Yarrowsburg Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Knoxville Md. R.1
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Annie E. Holmes

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife George W. Holmes7. Birth date of deceased (mo., day, yr.) September 16 - 1884

6. (c) If alive, give age _____ years

8. AGE: Years 64 Months 1 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace Burkittsville Fred. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name George Burkitt13. Birthplace Fred. Co. Md14. Maiden name Sorens. Ausherman15. Birthplace Fred. Co. Md.16. Informant Mrs. Charles LongAddress Boonsboro Md.17. Burial Date thereof Oct 31, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Burkittsville CemeteryLocation Burkittsville Md.18. Funeral director Wm J. Bart & SonsAddress Boonsboro Md.19. Oct 31 19 48 Cornelius H. Castle
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 48 at 2:15 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 19 48 to Oct 28 19 48
and that I last saw him alive on Oct. 20 19 48

Immediate cause of death _____ DURATION _____

Coronary Thrombosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William M. W. M. D. or other _____Address Boonsboro Date signed 10/29/48

MARGIN RESERVED FOR BINDING

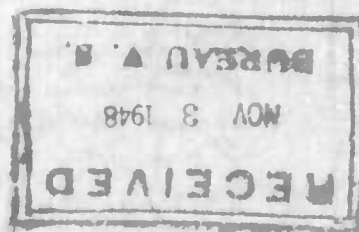
VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. L. Lang

M

I



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10814

462 X

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
618 Washington Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 618 Washington Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Laura B. Hoover

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 Female White Married
 6.(b) Name of husband or wife Silas M. Hoover
 8.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) July 27, 1873
 8. AGE: Years Months Days If less than one day
75 2 23 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

12. Name Jacob Zeigler
 13. Birthplace Hagerstown, Maryland
 14. Maiden name Belle E. Stouffer
 15. Birthplace Hagerstown, Maryland
 16. Informant Silas M. Hoover

Address Hagerstown, Maryland
 17. Burial Date thereof 10-22-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Oct. 22, 48 Phoebe Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1948 at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23, 1948 to Oct. 19, 1948
 and that I last saw him alive on October 19, 1948

Immediate cause of death Carcinoma of sigmoid. DURATION ?

Due to

Due to

Other conditions Chronic myocarditis 2 years

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ra Bell M. D. or other

Address Hagerstown, Md. Date signed 10/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10815

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

339 Jefferson St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 339 Jefferson St.

(If rural, give LOCATION)

2.(a) If veteran, name was

3. (a) FULL NAME

Gertrude M. Hose

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 22, 1881

8. AGE:

Year

Months

Days

It less than one day

67

4

14

hrs.

min.

9. Birthplace

Bridgeport Wash. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name

William A. Hose

13. Birthplace

Hagerstown Md.

MOTHER

14. Maiden name

Elizababeth Baughman

15. Birthplace

Hagerstown Md.

16. Informant

Miss Mary Hose

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-9-48

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

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Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 3:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
On Oct 6 1948 to post mortem.

and that I saw him alive on 19

Immediate cause of death

Coronary insufficiency

DURATION

Due to

Arteriosclerotic heart disease

Due to

(Should be confirmed or
diagnosed by regular physician)

Other conditions

The above is caused by
Dr. D. B. Kneerly.

Major findings of operations

Dr. Diabetes mellitus (Refused to
take insulin)

Major findings of operations

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. 11/23/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

ROBERT F. READLE

M. D. or other

Address

132 W. WASHINGTON ST.

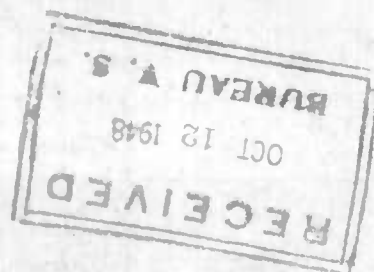
Date signed 10-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Wells

10827

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
1 Hr.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington C., Hospital
 How long in hospital or institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Broadforing.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None
 (If rural, give LOCATION)
 2. (a) If veteran, name war No

3. (a) FULL NAME

John Edward Hose

3. (b) Social Security Number

No

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife None
 7. Birth date of deceased (mo., day, yr.) March 30, 1946
 8. AGE: Year 2 Month 6 Days 20 If less than one day hr. min.

9. Birthplace Maugansville Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Francis Hose

13. Birthplace Wilson, Md.

14. Maiden name Martha Bartles

15. Birthplace Hagerstown, Md.

16. Informant Francis Hose

Address Broadforing, Md.

17. Burial Date thereof 10/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadforing Cemetery

Location Broadforing, Maryland

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland

19. Oct 23 1948 Chas. H. Kover
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 5:50

20. DATE OF DEATH Oct 20, 1948 at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Intra thoracic hemorrhage

Due to and shock

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Oct/20/48

Where did injury occur? Route #4 Hagerstown Wash. Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury ran over by truck Injured at work? no

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.
 Address Hagerstown, Md. WASH. CO., MD.
 Date signed 10/22/48

RECEIVED
OCT 28 1948
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10816

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County... Washington
 City or town... Bonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 years
 Hospital, institution, or street address where death occurred:
S. main St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Bonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... S. main St.
 (If rural, give LOCATION)
 2(a) If veteran, name war... No

3. (a) FULL NAME

Charles William Humphrey

3. (b) Social Security Number

213-12-7224

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... married

6. (b) Name of husband or wife... Jennie Norris Humphrey

7. Birth date of deceased (mo., day, yr.)... December - 3 - 1881 6. (c) If alive, give age... years

8. AGE: Years... 66 Months... 10 Days... 19 If less than one day... hrs. min.

9. Birthplace... Pawpaw W. Va.
 (Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business

12. Name... William Humphrey

13. Birthplace... England

14. Maiden name... Elizabeth Rabner

15. Birthplace... Bonsboro Wash. Co. Md.

18. Informant... Mrs. Jennie Humphrey

Address... Bonsboro Md.

17. Burial Date thereof... October 25, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Bonsboro Cemetery

Location... Bonsboro Md.

18. Funeral director... Wm. J. Best & Sons

Address... Bonsboro Md.

19. Oct. 23 19 48 John H. Best
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 22 19 48 at 9:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 19 48 to October 22 19 48 and that I last saw him alive on October 22 19 48

Immediate cause of death... Cerebral Haemorrhage

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... John H. Best M. D. or other

Address... Bonsboro Date signed 10/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

421 Elizabeth StreetHow long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 421 Elizabeth St.
(If rural, give LOCATION)2.(a) If veteran, name war no.

3. (a) FULL NAME

Minnie V. Huntzberry

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Earl Huntzberry7. Birth date of deceased (mo., day, yr.) December 8 - 1879

8. AGE: Years Months Days If less than one day

68 10 19 hrs. min.9. Birthplace Bonsboro Wash. Co. Md.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business own home12. Name Lawson Wilkerson13. Birthplace Bonsboro Wash. Co. Md.14. Maiden name Julia Eagle15. Birthplace Virginia16. Informant Earl HuntzberryAddress 421 Elizabeth St. Washington Md.17. Burial Date thereof Oct. 30, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Washington Md.18. Funeral director Wm. J. Bart & SonsAddress Bonsboro Md.19. October 29, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 23, 1948 to Oct 27, 1948and that I last saw him alive on October 26, 1948Immediate cause of death Intestinal obstruction DURATION 4 days

Due to

Due to

Other conditions Hemiplegia, left 3 yearsArteriosclerosis 20 years

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death could be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Ra Bee M. D. or otherAddress Washington Md. Date signed 10/27/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

421 Elizabeth StreetHow long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 421 Elizabeth St.
(If rural, give LOCATION)2.(a) If veteran, name war no.

3. (a) FULL NAME

Minnie V. Huntzberry

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Earl Huntzberry7. Birth date of deceased (mo., day, yr.) December 8 - 1879

8. AGE: Years Months Days If less than one day

68 10 19 hrs. min.9. Birthplace Bonsboro Wash. Co. Md.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business own home12. Name Lawson Wilkerson13. Birthplace Bonsboro Wash. Co. Md.14. Maiden name Julia Eagle15. Birthplace Virginia16. Informant Earl HuntzberryAddress 421 Elizabeth St. Washington Md.17. Burial Date thereof Oct. 30, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Washington Md.18. Funeral director Wm. J. Bart & SonsAddress Bonsboro Md.19. October 29, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 23, 1948 to Oct 27, 1948and that I last saw him alive on October 26, 1948Immediate cause of death Intestinal obstruction DURATION 4 days

Due to

Due to

Other conditions Hemiplegia, left 3 yearsArteriosclerosis 20 years

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death could be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

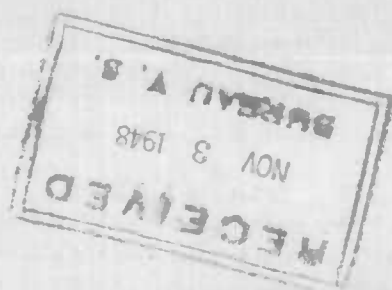
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Ra Bee M. D. or otherAddress Washington Md. Date signed 10/27/48



MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

61

10818

Reg. Dist. No. 144

1. PLACE OF DEATH:
County Prince Georges Washington
City or town Rural Brunswick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Garlinger Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME Ada E. Hurd

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Roy E. Hurd

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1893

8. AGE: Years 55 Months 6 Days 12 If less than one day hrs. min.

9. Birthplace Welsh Run, Pa.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name William Gorman

13. Birthplace Franklin Co., Pa.

14. Maiden name Anna Guessford

15. Birthplace Franklin Co., Pa.

16. Informant Roy E. Hurd

Address 28 Garlinger Ave. - Hagerstown

17. Burial Date thereof Nov. 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Funkstown Cemetery

Location Funkstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. 10-29 1948 Eugenia H. Burke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948 19 6:00 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1948 to Oct. 29, 1948

and that I last saw him alive on Oct. 28, 1948

Immediate cause of death Myocardial infarction

Due to Diabetes mellitus

Due to

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically. Md.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

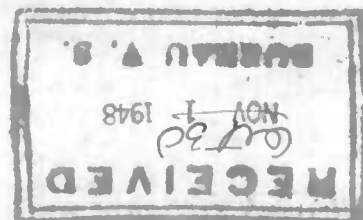
When did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugenia H. Burke M. D. or other 10-29-48
Address Brunswick, Md. Date signed

DURATION
10 yrs.
11 yrs.
2 yrs.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10819

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred
2 Kaplans Court
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 Kaplans Court
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William H. Jett

3. (b) Social Security Number

220-10-3815

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Louise Jett
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) October 22, 1893

8. AGE: Years 55 Months 6 Days 6 It less than one day
 hrs. min.

9. Birthplace Amosville, Virginia
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Louise Jett

Address 2 Kaplans Court

17. Burial Date thereof 11/1/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director William L. Brown

Address 2917 Federal St Hagerstown

Nov. 1, 1948 Registrar

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1948 at 4:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death.....

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RECEIVED
NOV 3 1948
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10820 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 80 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 45 E. Baltimore St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Frederick Sheridan Kale

3. (b) Social Security Number

219-20-0569

4. Sex..... Male
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Mary M. Kale
 7. Birth date of deceased (mo., day, yr.)..... May 13, 1868
 6. (c) If alive, give age..... years

8. AGE: Years..... 80 Months..... 5 Days..... 12
 If less than one day..... hrs. min.

9. Birthplace..... Washington County Md.
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business..... None

12. Name..... Kale

13. Birthplace..... Germany

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Clyde Kale

Address..... Hagerstown Md.

17. Burial..... Oct. 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown Md.

19. Oct. 29, 1948
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 26, 1948 at 9:10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 2, 1948 to Oct. 26, 1948
 and that I last saw him alive on Oct. 26, 1948

Immediate cause of death.....
Obstruction of the
common bile duct.

Due to.....
Carcinoma of the head of the
pancreas.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D.

Address..... Hagerstown Md.

Date signed..... 10/28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

10821

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
City or town Mt. Cather Rd. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Hagerstown Md. R.I.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Mt. Cather Road Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown Md. R.I.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Walter Fred Kershner

3. (b) Social Security Number

None

4 Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) October - 1 - 1948 6.(c) If alive, give age 30 years

8. AGE: Years — Months — Days 30 hrs. — min.

9. Birthplace Hagerstown Md. R.I.
(Town, county, and state)

10. Usual occupation home

11. Industry or business —

12. Name Leonard Kershner

13. Birthplace near Fitchman Wash. Co. Md.

14. Maiden name Helma Dumanpower

15. Birthplace Hagerstown Wash. Co. Md.

16. Informant Leonard Kershner

17. Burial Burial Date thereof Nov. 2, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Wm. J. Bart & Sons
Address Boonsboro Md.

19. Nov. 2, 1948 Registrar Chas. H. Powers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 19 48 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/31/48 to 10/31/48 and that I last saw him on 10/31/48

Immediate cause of death Asphyxia from
overlying

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Antopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Oct. 31, 48

Where did injury occur? Hagerstown Wash. Md. RFD
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home
Means of injury asphyxiation in bed clothing Injured at work? —

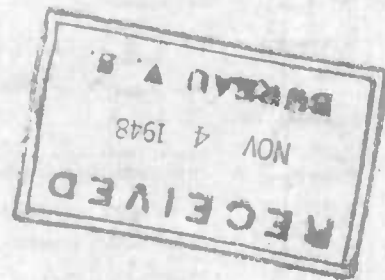
23. SIGNATURE C. F. Gering
M. D. or other —

Date signed 10/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age in especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, with UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30d

10822

1. PLACE OF DEATH:

County Washington
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 54 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wash.
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Martha Minerva Knode

3. (b) Social Security Number
None

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Widowed
------------------	---------------------------	---------------------------------------------------------

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 5, 1894
 6. (c) If alive, give age _____ years

8. AGE:	Years 54	Months 10	Days 24	If less than one day _____ hrs. _____ min.
---------	-------------	--------------	------------	-----------------------------------------------

9. Birthplace Sharpsburg--Washington--Md
 (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name William Boyer13. Birthplace Sharpsburg, Md14. Maiden name Martha Mose15. Birthplace Sharpsburg, Md16. Informant Mrs. Melva RyanAddress Hagerstown, Md

17. Burial Date thereof Nov. 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. ViewLocation Sharpsburg, Md18. Funeral director R. I. EarnshawAddress Keedysville, Md

19. 10-30 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 19 48 at 7:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 18, 1947 to Oct. 29 19 48
 and that I last saw her alive on 10/29/48 19 _____

Immediate cause of death
Acute right sided heart failure
 Due to Chronic luetic aortitis and myocarditis
 Due to _____

DURATION

1 day
5 years

Other conditions Tuberc Dorsalis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Shealy M.D. M. D. or otherAddress Sharpsburg, Md. Date signed 10/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 805

10823

1640

1. PLACE OF DEATH:

County WASHINGTON
City or town RURAL - BEAVER CREEK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HAGERSTOWN RT. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)Street No. 122 N. LOCUST ST.

(If rural, give LOCATION)

2. (a) If veteran, name war

NON-VET.

3. (a) FULL NAME

CLARENCE HOWARD

3. (b) Social Security Number

215-03-3482

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

SUSAN RANELS

7. Birth date of deceased (mo., day, yr.)

JULY 18, 1888

8. AGE:

Years

Months

Days

If less than one day

60313

hrs.

min.

9. Birthplace

SHARPSBURG WASHINGTON, MD.
(Town, county, and state)

10. Usual occupation

BOOK KEEPER

11. Industry or business

CHEMICAL CO.

FATHER

12. Name

HIRAM KRETZER

MOTHER

13. Birthplace

BEAVER CREEK, MD.

14. Maiden name

ADA SNAVELY

15. Birthplace

SHARPSBURG, MD.

16. Informant

Mrs. Mabel E. Moore

Address

122 N. Locust St. Hagerstown, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

11/13/48
(month) (day) (year)

Cemetery or crematory

Rose Hill

Location

Hagerstown, Md.

18. Funeral director

W. J. Holmquist

Address

Hagerstown, Md.

19. (Date rec'd by registrar)

Nov 20, 1948John D. Burt

Registrar

MEDICAL CERTIFICATION About

20. DATE OF DEATH October 31, 1948 at 11:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him

alive on

19

Immediate cause of death

Gunshot wound through mouth into head

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10/31/48Where did injury occur Hagerstown Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Beaver Creek RoadMeans of injury Gunshot .32 Injured at work? No

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. or other

23. SIGNATURE S. Robert WallHagerstown, Md.

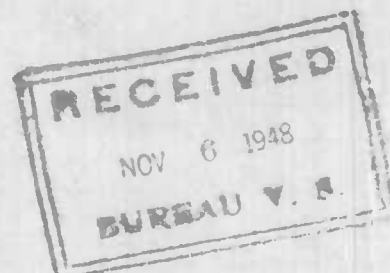
Address

Date signed 11/1/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

FILM No. G 117 NOV 8 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462 ✓

10824

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:
134 W. Washington Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 134 W. Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Stella T. Lantz

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife J. Scott Lantz

7. Birth date of deceased (mo., day, yr.) January 21, 1884 6. (c) If alive, give age _____ years

8. AGE: Years 64 Months 03 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Hebron, W. Va.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

FATHER 12. Name George W. Twyford

13. Birthplace W. Virginia

MOTHER 14. Maiden name Lenora Smith

15. Birthplace W. Virginia

16. Informant J. Scott Lantz

Address 134 W. Wash. St. Hagerstown, Md.

17. Burial Date thereof Oct. 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Oct 30 19 48 Pharrell Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 19 45 to Oct 28 19 48
and that I last saw him alive on Oct 27 19 48

Immediate cause of death Carcinoma Rectum DURATION 3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

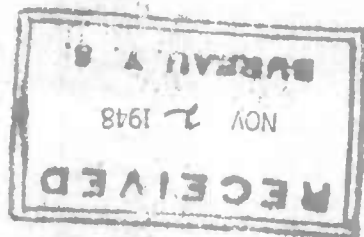
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Porterfield M.D.
M. D. or other

Address 136 W W Washington Date signed 10/29/48



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF ~~STILLBIRTH~~

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

10825

Reg. Dist. No. 302

1. PLACE OF BIRTH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution: Washington Co. Hospital
Length of mother's stay in County 22 years
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1103 Salem Ave
(If RURAL give LOCATION)

3. Name of child Baby Girl Linbaugh
5. Sex Female 6. Twin or triplet

4. Date of birth 10-20 1948 Hour 3:05 P.M.
7. No. of weeks pregnancy 20

FATHER OF CHILD

8. Full name Robert Cassin Linbaugh
9. Color W. 10. Age at time of this birth 26 yrs.
11. Usual occupation Sailchild Aircraft

MOTHER OF CHILD

12. Full maiden name Helen Marie Hornermale
13. Color White 14. Age at time of this birth 22 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? During labor?

18. Pregnancy, complications of

19. Labor: (a) Complications of (b) Induced?

20. (a) Was there an operation for delivery? (Yes or No)
(b) State all operations, if any

(c) Did child die before operation?
During operation?

23. (a) Burial (b) Date thereof Oct 22 - 1948
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cemetery

24. (a) Funeral director Scott F. Mumma & Son
(b) Address Hagerstown Md

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Placenta (5 min)
(b) Maternal causes

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature [Signature]
(Specify if M. D., midwife, or other)

Address Hagerstown Md

25. (a) Oct 23 1948 (b) Birth Room
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

Child Lived 1' 40"



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10826

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County WashingtonCity or town near Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

Williamsport Md.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 823 Virginia Avenue
(If rural, give LOCATION)2. (a) If veteran, name war No

3. (a) FULL NAME

Sarah E. Lowery

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Rev. William L. Lowery

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 20, 1873

8. AGE:

Years

Months

Days

It less than one day

75620

hrs.

min.

9. Birthplace

near Williamsport Md.
(Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER FATHER

12. Name

Isiah Davis

13. Birthplace

Doungville Wash. Co. Md.

14. Maiden name

Jamie Davis

15. Birthplace

Doungville Wash. Co. Md.

16. Informant

Mrs. Paul Kitchen

Address

Williamsport Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof October 13, 1948
(month) (day) (year)

Cemetery or crematory

Manor Cemetery

Location

near Tilghmanton Wash. Co. Md.

18. Funeral director

Wm J. Bart & Sons

Address

Boonsboro Md.

19. Oct-13-48

(Date rec'd by registrar)

19

Mrs. E. Lee M. Elroy
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948 at 5-P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1, 1948 to Oct 10, 1948and that I last saw him alive on Oct 10, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

7 days

Due to

Arterio Sclerosis5 years

Due to

Aortic Aneurysm?

Other conditions

non-syphilitic

(Include pregnancy within 3 months of death)

11/23/48

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David P. Brewer M.D.
M. D. or otherAddress Clear Spring Md. Date signed 10/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Brewer
11/23/48
2197
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 161a 10828 202

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 day
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md. County..... Wash.
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 519 N. Locust St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Linda Louise Martin

3. (b) Social Security Number

4. Sex..... female
 5. Color or race..... white
 6. (a) Single, married, widowed, or divorced.....
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... October 30, 1948
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.
1

9. Birthplace..... Hagerstown, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business..... (1)

12. Name..... Robert LeRoy Martin
 13. Birthplace..... York, Penna.

14. Maiden name..... Mary Louise Hoover15. Birthplace..... Hagerstown, Md.

16. Informant..... Robert LeRoy Martin
 Address..... Hagerstown, Md.

17. burial Date thereof..... 11-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Md.

18. Funeral director..... Scott F. Minnich & Son
 Address..... Hagerstown, Md.

19. Nov. 1 1948 Health Officer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 31, 1948 at 6:13 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1948 to October 31, 1948
 and that I last saw him alive on October 31, 1948

Immediate cause of death..... Congenital atelectasis
(1 mo. gestation)
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... None Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Robert LeRoy Martin M. D. or other.....
 Address..... Hagerstown, Md. Date signed..... 10/31/48

RECEIVED
NOV 8 1940
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10829

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>40 years</u> Hospital, institution, or street address where death occurred: <u>Washington County Home</u> How long in hospital or institution?..... <u>3 years</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md.</u> County..... <u>Wash.</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....		
3. (a) FULL NAME <u>Wilbur Overall Matthews</u>			3. (b) Social Security Number -		
4. Sex <u>male</u>			5. Color or race <u>white</u>		
6. (a) Single, married, widowed, or divorced <u>widowed</u>			MEDICAL CERTIFICATION		
8. (b) Name of husband or wife <u>Maude Matthews</u>			20. DATE OF DEATH <u>Oct. 30</u> 19 <u>48</u> at <u>6:00 a.m.</u>		
7. Birth data of deceased (mo., day, yr.) <u>October 12, 1879</u>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Oct 28</u> 19 <u>48</u> to <u>Oct 30</u> 19 <u>48</u> and that I last saw him alive on <u>Oct 29</u> 19 <u>48</u>		
8. AGE: Years <u>79</u> Months <u>-</u> Days <u>18</u> It less than one day hrs. min.			6. (c) If alive, give age years		
9. Birthplace <u>Bentenville, Warren Co., Va.</u> (Town, county, and state)			Immediate cause of death <u>Hypertensive Heart Disease</u> <u>Arterio Sclerosis</u>		
10. Usual occupation <u>Engineer</u>			DURATION <u>1 yr</u> <u>36 yrs</u>		
11. Industry or business <u>n + w Railroad</u>			Due to		
MOTHER FATHER			Due to		
12. Name <u>Joseph G. Matthews</u>			Other conditions		
13. Birthplace <u>Page Co., Va.</u>			(Include pregnancy within 3 months of death)		
14. Maiden name <u>Rachel Walter</u>			Major findings at operations		
15. Birthplace <u>Page Co., Va.</u>			Date of op.		
16. Informant <u>Owen K. Williamson</u> <u>Hagerstown, Md.</u>			Autopsy results		
Address			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
17. burial Date thereof <u>10-31-48</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <u>Rest Haven Cemetery</u> Cemetery or crematory <u>Hagerstown, Md.</u> Location			22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?		
18. Funeral director <u>Scott F. Minnich & Son</u> <u>Hagerstown, Md.</u> Address			23. SIGNATURE <u>G. H. Binkley, M.D.</u> M. D. or other <u>Hagerstown</u> Date signed <u>10/30/48</u>		
19. Oct. 31 1948 (Date rec'd by registrar) Registrar			Address		



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Big Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. Big Spring Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Herbert McAllister

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Lyda

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 18958. AGE: Years 53 Months 3 Days 28 If less than one day
hrs. min.9. Birthplace Washington county, Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John W. McAllister13. Birthplace Maryland14. Maiden name Georgiana Weaver15. Birthplace Maryland16. Informant Richard McAllisterAddress Hagerstown, Maryland17. Burial Date thereof Oct. 20, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Clear Spring, Maryland18. Funeral director Snyder & RowlandAddress Clear Spring, Maryland19. Oct. 20, 1948 Registrar Charles Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948 at 9:40 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1948 to Oct. 17, 1948 and that I last saw him alive on Oct. 16, 1948

Immediate cause of death

DURATION

Cardiovascular Disease July 24, 1948Due to Acute Cardiac FailureDue to Decompensation Sept. 15, 1948

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature W. Howard YeagerAddress Hagerstown, Md

M. D. number

Date signed 10-18-4819. Oct. 20, 1948 Registrar Charles Bowers

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

WASHINGTON-COUNTY - HOME

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Noah L. Meeks

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Selba Meeks

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1870

8. AGE: Years 78 Months 7 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Bedford Co. Penna
(Town, county, and state)

10. Usual occupation Retired R.R. Employee

11. Industry or business

12. Name Unknown

13. Birthplace Penna

14. Maiden name Unknown

15. Birthplace Penna

16. Informant David B. Meeks

Address 7 S. Dayton Ave. Brunswick, Maryland

17. Burial Date thereof Oct. 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

19. Oct 28, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948 at 2.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 20 1948 to Oct 26 1948

and that I last saw him alive on Oct 25 1948

Immediate cause of death

Arterio Sclerosis
the glomerulonephritis

DURATION

10 yrs
3 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work?

23. SIGNATURE O.H. Binkley M.D.

Address Hagerstown, Md Date signed 10/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 830 10832 304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 yrs.Hospital, institution, or street address where death occurred:
Blue HillHow long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. Blue Hill
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Howard S. Mellott

3. (b) Social Security Number

89-705-10-7943

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MarriedB.(b) Name of husband or wife Anna Fitty Mellott7. Birth date of deceased (mo., day, yr.) August 10, 18736.(c) If alive, give age 65 years8. AGE: Years 75 Months 2 Days 1 If less than one day — hrs. — min.9. Birthplace Needmore, Fulton Co., Penna.
(Town, county, and state)10. Usual occupation Retired Railroader

11. Industry or business

12. Name Calvin Mellott13. Birthplace Unknown14. Maiden name Harriet Lake15. Birthplace Unknown16. Informant Mrs. Anna F. MellottAddress Blue Hill, Hancock, Md.17. Burial Date thereat Oct 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Thomas EpiscopalLocation Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 10/14/48 19 48 J. M. Vetter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 19 48, at 11 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/12 19 48, to 10/11 19 48and that I last saw him alive on 10/10 19 48Immediate cause of death Cerebral hemorrhage

DURATION

Due to HypertensionDue to ArteriosclerosisOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. M. Vetter M.D.

M. D. or other

Address Hancock, Md. Date signed 10/12/48

RECEIVED
OCT 18 1948
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **306**

10833

1. PLACE OF DEATH:

County Wash
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 16 days
Hospital, institution, or street address where death occurred: Hitchcock Hosp.
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1600 Northwood Rd.
(If rural, give LOCATION)
2.(a) if veteran, name war ✓

3. (a) FULL NAME

John Miller

3. (b) Social Security Number

024-01-2090A

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Alice Hay
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30 - 1876

8. AGE: Years 72 Months 2 Days 6 If less than one day hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

12. Name John Miller

13. Birthplace Glasgow, Scotland

14. Maiden name Jessie Miller

15. Birthplace Glasgow Scotland

16. Informant Hosp. records

Address

17. Burial Date thereof Oct 9 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Newburyport, Mass.

18. Funeral director Frank H. Quirell

Address Pikesville, Md.

19. 10/6 19 48 S.W. Hedrick
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 19 48, at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 19 48 to Oct 6 19 48
and that I last saw him alive on Oct 5 19 48

Immediate cause of death Cerebral Arteriosclerosis

Due to

Due to

Other conditions Paralysis agitans
Latent syphilis
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T.M. Armstrong, M.D.
Hitchcock Hospital
Address Pikesville, Md. Date signed 10/6/48

DURATION

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MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

703

RECEIVED

OFFICE OF THE

12



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

10834

4805

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yearsHospital, institution, or street address where death occurred:
141 N. Conococheague St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 141 N. Conococheague St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Marian Elizabeth Mitchell

3.(b) Social Security Number

216-22-9155

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
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6.(b) Name of husband or wife Daniel Fredrick Mitchell6.(c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) December 11, 1914

8. AGE: Years <u>33</u>	Months <u>10</u>	Days <u>0</u>	If less than one day hrs. min.
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9. Birthplace Chambersburg, Franklin, Penna.
(Town, county, and state)10. Usual occupation Clerk
Drug Store

11. Industry or business

12. Name Rev. B. F. Kinzer13. Birthplace Chambersburg, Penna.14. Maiden name Mrs. Alice Kinzer15. Birthplace Altoona, Penna.16. Informant Mr. Daniel Fredrick Mitchell
Address Williamsport, Md.17. Burial Data thereof Oct. 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Maryland18. Funeral director Edith v. LeafAddress Williamsport, Md.19. Oct-13- 48 Mrs E Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/48 19 10, at 9:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/11/48 19 10 to 10/11/48 19 10and that I last saw him alive on 10/11/48 19 10Immediate cause of death Pericarditis
acute & hypertensive DURATION 4 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. F. Young M. P. or otherAddress Williamsport, Md. Date signed 10/12/48

RECEIVED

OCT 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10835

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Rural Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route 40 (St. Paul's.)
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Dorie Virginia Moore

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) Sept. 29, 1934 6. (c) If alive, give age _____ years
 8. AGE: Years 14 Months 1 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County, Md.
 (Town, county, and state)
 10. Usual occupation School Student
 11. Industry or business
 12. Name Abram S. Moore
 13. Birthplace Wash. Co., Md.
 14. Maiden name Corolla B. Shank
 15. Birthplace Wash. Co., Md.
 16. Informant Abram S. Moore
 Address Clear Spring, Md. R D
 17. Burial Burial Date thereof Oct. 27-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Route 40 near Clear Spring, Md.
 18. Funeral director Snyder-Rowland Funeral Home
 Address Clear Spring, Md.
 19. Oct 26, 1948 Registrar Chas. H. Rowland
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948 5:15 P. M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from _____ to _____
 and that I last saw him _____ alive on _____
 Immediate cause of death Fractured skull DURATION 2 hrs
intra cranial hemorrhage
and shock
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations None Date of op. _____
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 10/24/48
 Where did injury occur? South east Clear Spring Wash. Ind.
 (City or town) (County) (State)
 Injured at home, farm, industry, or public place (where?) Highway Route #40
 Means of injury Hit by auto Injured at work? No
 DEPUTY MEDICAL EXAMINER S. R. Riker & Keeler WASH. CO., MD.
 23. SIGNATURE Hagerstown, Md. Date signed 10/25/48
 Address _____



Birth and Death 10836
159

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution: Washington County Hospital
Length of mother's stay in County 17 years
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If RURAL give LOCATION)

3. Name of child

Boy Moser #1

5. Sex

male

6. Twin or triplet

Turn

4. Date of birth

Oct 17 1948 Hour 3:13 P.M.

7. No. of weeks pregnancy

20 weeks

FATHER OF CHILD

8. Full name Claude Raymond Smith
9. Color W 10. Age at time of this birth 22 yrs.
11. Usual occupation Clerk - grocery store

MOTHER OF CHILD

12. Full maiden name Marie Martha Moser
13. Color W 14. Age at time of this birth 17 yrs.
15. Usual occupation unemployed

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Hydramnios

19. Labor: (a) Complications of none
(b) Induced? No

20. (a) Was there an operation for delivery? No
(b) State all operations, if any _____
(Yes or No)

(c) Did child die before operation? _____
During operation? _____

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Unknown

(b) Maternal causes Hydramnios

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Robert T. Kadle
(Specify if M. D., midwife, or other)

Address 132 N. Wash St. Hagerstown

23. (a) _____ (b) Date thereof _____
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory _____

24. (a) Funeral director _____
(b) Address _____

25. (a) Oct. 21, 1948 (b) Chas. H. Powers
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per _____

* See Instruction C on stub.

Child lived 33 min

RECEIVED

OCT 23 1948

BUREAU V. S.

~~Birth and Death~~
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

10837

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
 City or town Seatons
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Washington County Hospital
 Length of mother's stay in County 14 yrs
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Washington
 City or town Bassboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If RURAL give LOCATION)

3. Name of child Boy Moser # 2

5. Sex male

6. Twin or triplet Twin

4. Date of birth Oct. 17 1948 Hour 3:35 P.M.

7. No. of weeks pregnancy 20 weeks

FATHER OF CHILD

8. Full name Claude Raymond Smith
 9. Color W 10. Age at time of this birth 22 yrs.
 11. Usual occupation Grocery Store Clerk

MOTHER OF CHILD

12. Full maiden name Marie Martha Moser
 13. Color W 14. Age at time of this birth 17 yrs.
 15. Usual occupation Unemployed

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
 (b) How many other children were born alive but are now dead? 1 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Hydramnios

19. Labor: (a) Complications of No
 (b) Induced? No

20. (a) Was there an operation for delivery? No
 (b) State all operations, if any _____
 (Yes or No)

(c) Did child die before operation? —
 During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes unknown

(b) Maternal causes Hydramnios

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Robert J. Kadle
 (Specify if M. D., midwife, or other)

Address 132 W. Wash St Seatons

23. (a) _____ (b) Date thereof _____
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory _____

24. (a) Funeral director _____

(b) Address _____

25. (a) Oct. 21, 1948 (b) Charles H. Bowers
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per _____

* See Instruction C on stub.

Child lived 35 min.

RECEIVED

OCT 23 1948

BUREAU V. 5.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1066

10838

306

1. PLACE OF DEATH:

County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 months 11 daysHospital, institution, or street address where death occurred: Reisterstown HospitalHow long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Md. County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 6704 Germanhill Rd.
(If rural, give LOCATION)2.(a) if veteran, name war ✓

3. (a) FULL NAME

Johau Nare or John Kusti Nare

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948, at 5:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Oct 21 1948and that I last saw him alive on Oct 20 1948Immediate cause of death Cerebral arteriosclerosis DURATIONDue to Ren. arteriosclerosis

Due to

Other conditions Chronic bronchitis + emphysemaCh. pneumonia (3) Enucleation of eye
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l place (where?)

Means of injury Injured at work?

23. SIGNATURE T.M. Armstrong, M.D. M.D. or otherAddress Reisterstown, Md. Date signed 10/21/486. (b) Name of husband or wife Unknown7. Birth date of deceased (mo., day, yr.) October 10 ? 18848. AGE: Years Months Days It less than one day
64 October 10 Finland
(Town, county, and state)10. Usual occupation Unknown

11. Industry or business

12. Name Alpa Nare13. Birthplace Finland14. Maiden name Eva ?15. Birthplace Finland16. Informant Hospital RecordsAddress Baltimore City Hosp.

17. Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematorium University Medical School NOV 19 1948Location Commissioner of Health

18. Funeral director

Address

19. 11/19/48 A.W. Hedrich Registrar

(Date rec'd by registrar)

VS A15 9.45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

6700 Germantown Road,
Armistead Gardens
- call. City Hosp.

NOV 19 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10839

301

131a

1. PLACE OF DEATH:

County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
1 South Artizan St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 South Artizan St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Laura Elmiere Nave

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Joseph M. Nave
Deceased 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 4, 1872
8. AGE: Years 76 Months 7 Days 20 If less than one day
hrs. min.

9. Birthplace Williamsport, Wash., Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
12. Name John Shank
13. Birthplace Washington County, Md.
14. Maiden name Sarah Gruber
15. Birthplace Washington County, Md.

16. Informant Edward Nave
Williamsport, Md.
Address

17. Burial Date thereof Oct. 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Riverview Cemetery
Location Williamsport, Md.
Edith V. Leaf
18. Funeral director
Address Williamsport, Md.

19. Oct 26 1948 E. Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 24, 1948 19....., at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
OCTOBER 12, 1948 19..... to OCTOBER 24 19.....
and that I last saw him OR alive on OCTOBER 23, 1948 19.....

Immediate cause of death.....
HYPERTENSIVE CARDIOVASCULAR
RENAL DISEASE
MYO CARDIAC DECOMPENSATION
CEREBRAL ACCIDENT (HEMOORRHAGE)
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

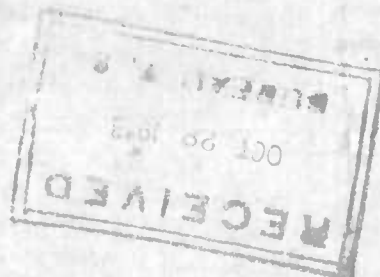
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, pub'c place (where?)
Means of injury Injured at work?

23. SIGNATURE Paulie Robert Cohen M. D. or other
Glenn Sprin End
Address..... Date signed 10-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-56M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 419 Carlton Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Snively Obitts

3. (b) Social Security Number

213-12-7274

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Estella Wolfe Obitts

deceased

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 16, 1881

8. AGE:

67 Years8 Months29 Days

If less than one day

hrs.

min.

9. Birthplace Williamsport, Wash., Maryland
 (Town, county, and state)

10. Usual occupation Laborer Street Maintenance
City of Hagerstown

11. Industry or business

12. Name George Obitts13. Birthplace Williamsport, Md.14. Maiden name Caroline Wolfe15. Birthplace Williamsport, Md.16. Informant Elmer ObittsAddress 419 Carlton Ave., Hagerstown, Md.

17. Burial

Date thereof Oct. 8, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress Williamsport, Md.

Address

Oct 7, 1948
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1, 1948 to Oct. 5, 1948
 and that I last saw him alive on Oct. 5, 1948

Immediate cause of death

Cerebral Hemorrhage
arterio-sclerosis
hypertension

DURATION

syn.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Bailey M.D.
Hagerstown, Md.
 Date signed Oct 7, 1948

M. D. or other

Address

Date signed

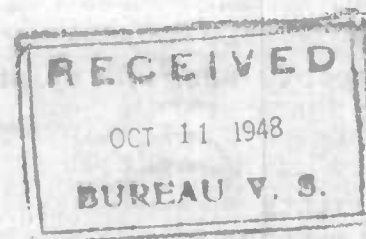
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10840



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr, Le Van

10841

Reg. Dist. No. 302-300

1. PLACE OF DEATH:

County..... Washington
 City or town..... Near Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 9 YEARS
 Hospital, institution, or street address where death occurred:
None
 How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Near Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
None
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME

William H. Orcutt Jr.

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 8. (b) Name of husband or wife..... Irene
 8. (c) If alive, give age..... 50 years
 7. Birth data of deceased (mo., day, yr.)..... October 13, 1896
 8. AGE: Years..... 52 Months..... 0 Days..... 9 If less than one day..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 21, 1948 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1948 to Oct 21 1948
 and that I last saw him alive on Oct 19 1948
 Immediate cause of death.....

DURATION

Carcinoma of liver
carcinoma of left lung

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

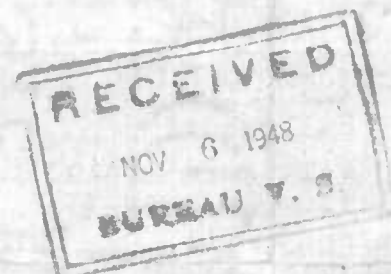
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Baltimore Date signed..... 10/24/48

9. Birthplace..... Hagerstown, Wash. Co., Md.
 (Town, county, and state)
 10. Usual occupation..... Railroader
 11. Industry or business..... Baltimore Ohio
 12. Name..... William H. Orcutt
 13. Birthplace..... Vermont, Ill.
 14. Maiden name..... Myrtle Grider
 15. Birthplace..... Greencastle, Pa.
 16. Informant..... Mrs Irene Orcutt
 Address..... Near Keedysville, Md
 17. Burial Date thereof..... 10/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Md
 18. Funeral director..... Andrew K. Coffman
 Address..... Hagerstown, Md
 19. 10-22 1948 Ely Boyer
 (Date rec'd by registrar) Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

10842

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
830 Virginia Ave
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown R # 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Western Pike
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

CLINTON HENRY PAYTON

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife —
 7. Birth date of deceased (mo., day, yr.) January 25 1914 6.(c) If alive, give age — years
 8. AGE: Years 34 Months 8 Days 27 If less than one day — hrs. — min.

9. Birthplace Shenandoah Va.
 (Town, county, and state)
 10. Usual occupation Unable to work
 11. Industry or business Physically Handicapped
 12. Name John H. Payton
 13. Birthplace Basic Va.
 14. Maiden name Agnes Cook
 15. Birthplace Canton Ill

16. Informant Mrs. Agnes Chapman
 Address Hagerstown Md.
 17. Burial Date thereof 10/25/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct 23, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948 19 — at 9.30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-48 19 — to 10-22-48 19 —
 and that I last saw him alive on 10-22-48 19 —
 Immediate cause of death Ischemic Paralysis (Chronic Fissured)
 Due to Flu Pneumonia
 Due to —
 Other conditions —
 (Include pregnancy within 3 months of death)
 Major findings of operations —
 Date of op. —
 Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE J. W. Smith M. D. or other —
 Address Hagerstown Md. Date signed 10/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County... Washington
City or town... Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 11 days
Hospital, institution, or street address where death occurred:
Bellevue Hospital
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegheny
City or town... Prestonburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 1
(If rural, give LOCATION)
2(a) If veteran, name war... ☒

3. (a) FULL NAME

Edith Leona Perry

3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Walter Perry

7. Birth date of deceased (mo., day, yr.)

June 16, 1917

6. (c) If alive, give age

36 years

8. AGE:

Years

Months

Days

If less than one day

31

4

1

hrs. min.

9. Birthplace

Milledgeville, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Charles Stevens

13. Birthplace

Maryland

14. Maiden name

Edna Kidder

15. Birthplace

Maryland

16. Informant

Hosp. Records

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof 10-20-1948
(month) (day) (year)

Cemetery or crematory

Valley Summit Methodist

Location

Valley Summit, Md.

18. Funeral director

James Baker

Address

Prestonburg, Ind.

19.

Oct 19th 1948

1948

Geo. W. Ferguson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 17

19 48 at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6

19 48

to Oct 17 19 48

and that I last saw him alive on Oct 17 19 48

Immediate cause of death

Congenital Syphilis & Erb's Spastic Paralysis

DURATION

Due to

Due to

Other conditions

Decubitus ulcers, severe Chronic urinary tract infection
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. Amington, M.D.
M. D. or other

Address

Bellevue Hosp., Wash. D.C.

Date signed 10/17/48

10843

306

306

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1915

BUREAU V. S.

76

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10844

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 85 years
 Hospital, institution, or street address where death occurred:
Boyd Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boyd Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Anthony Porter

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Irene H. Porter

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1862 8. (c) If alive, give age _____ years

8. AGE: Years 85 Months 11 Days 10 It less than one day _____ hrs. _____ min.

9. Birthplace Clear Spring, Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name William Porter13. Birthplace Unknown14. Maiden name Georgiana Long15. Birthplace Hancock, Md.16. Informant Nora E. PorterAddress Clear Spring, Md.17. Burial Date thereof Oct. 23, 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory AME CemeteryLocation Clear Spring, Md.18. Funeral director Snyder-Roland Funeral HomeAddress Clear Spring, Md.19. Oct 23, 48 Joseph W. Murray Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1948 9:15 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6, 1948 to Oct 20, 1948
 and that I last saw him alive on Oct 19, 1948

Immediate cause of death

Chr. Myocardial Sclerosis

Due to

Due to

Due to

Due to

Other conditions Chr. Bronchiectasis
Chr. Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David P. Brewer M.D.Address Clear Spring Md. Date signed 10/21/48

M. D. or other

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 27 1948
BUREAU A. S.

RECEIVED
OCT 27 1949
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 weeks
 Hospital, institution, or street address where death occurred:
Williamsport Nursing Home
 How long in hospital or institution? 11 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 128 South Mulberry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Derbie S. Potter

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Clyde J. Potter
 7. Birth date of deceased (mo., day, yr.) August, 31, 1876
 6.(c) If alive, give age years
 8. AGE: Years 72 Months 1 Days 26 If less than one day hrs. min.

9. Birthplace Keedysville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Jacob Reed
 13. Birthplace Sharpsburg Wash. Co. Md.
 14. Maiden name Anna Greeting
 15. Birthplace Keedysville Wash. Co. Md.

16. Informant Clyde J. Potter
 Address 128 S. Mulberry St. Hagerstown Md
 17. Burial Date thereof October 30, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Roherville Cemetery
 Location Roherville Md.
 18. Funeral director Wm J. Best & Sons
 Address Boonsboro Md
 19. Oct. 29. 19 48 C Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 19 48 at 3 P. M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 47 to Oct 27 19 48
 and that I last saw him alive on Oct 9 19 48.
 Immediate cause of death Chronic failure of the excretory glands.
 Due to
 Due to
 Other conditions Chronic Valvular Heart Disease.
 (Include pregnancy within 3 months of death)

DURATION

1 yr.

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE C. Lee McElroy M. P. or other 1486-1011-10/27/48
 Address 1486-1011-10/27/48 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

10846

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 Hours

Hospital, institution, or street address where death occurred:

1019 Oak Hill Ave

How long in hospital or institution?

--

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 535 West Howard St.
 (If rural, give LOCATION)

2.(a) Is veteran, name war

None

3. (a) FULL NAME

HARRY WILLIAM POTTS

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lela Grace

7. Birth date of deceased (mo., day, yr.) October 10 1880 6. (c) If alive, give age 61 years

8. AGE: Years 68 Months 0 Days 12 If less than one day
 hr. min.

9. Birthplace Williamsport wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Machinist11. Industry or business Retired12. Name Adolphus Potts

13. Birthplace

14. Maiden name Catherine Worley

15. Birthplace

16. Informant Mrs Lela PottsAddress Hagerstown Md.

17. Burial Date thereof 10/25/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Oct. 23. 48 Charles H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948 19... at 12:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

DURATION

Due to acute cerebral hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

23. SIGNATURE S. R. Wells M. D.

Hagerstown, Md. Date signed 10/23/48

RECEIVED
OCT 28 1948
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:
331 Mont Valla Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 331 Mont Valla Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War 1

3. (a) FULL NAME

Harry David Propes

3. (b) Social Security Number

705-10-4949

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Sarah Propes
 7. Birth date of deceased (mo., day, yr.) Feb 22, 1894
 8. AGE: Year 54 Month 8 Day 7 If less than one day _____ hrs. _____ min.

9. Birthplace Little Rock, Arkansas
 (Town, county, and state)
 10. Usual occupation Mechanic
 11. Industry or business
 12. Name Propes
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mrs. Sarah Propes
 Address 331 Mont Valla Ave.-Hagerstown, Md.
 17. Burial Date thereof Nov. 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Md.
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. Nov 1, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Acute coronary occlusion
Due to Arterio Sclerotic
Coronary heart disease
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

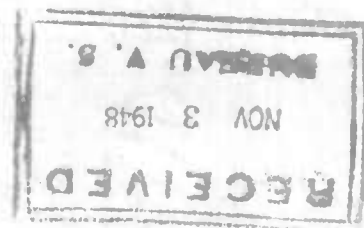
Means of injury _____ Injured at work? _____

DEPUTY MEDICAL EXAM.

23. SIGNATURE S. P. Wells WASH. CO., MD.

M. D. or Other _____

Address Hagerstown, Md. Date signed 10/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10847

302

1. PLACE OF DEATH:

Washington
County.....Hagerstown
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
Maryland
State..... County WashingtonHagerstown
City or town.....
(If outside city or town limits, write RURAL and give nearest town)57 Elizebeth St.
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas A. Renner

3. (b) Social Security Number

213-10-6848

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife..... Grace E. Renner

7. Birth date of deceased (mo., day, yr.) November 3, 1875

8. AGE: Years Months Days If less than one day

72

11

8

hrs. min.

9. Birthplace..... Hagerstown Wash. Md.

(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... North American Cement Co.

12. Name..... William Renner

13. Birthplace..... Hagerstown Md.

14. Maiden name..... Margaret Luft

15. Birthplace..... Hagerstown Md.

16. Informant..... Mrs. William S. Garling

Address..... Hagerstown Md.

17. Burial Date thereof 10-14-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown Md.

19. Oct. 13, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 11, 1948 3:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1948, to Oct. 11, 1948

and that I last saw him alive on Oct. 11, 1948

Immediate cause of death..... Cardiac - Vascular Disease

DURATION

6 M.

Due to.....

Due to.....

Other conditions..... Pericardial Hypertrophy

1 1/2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H. Campbell

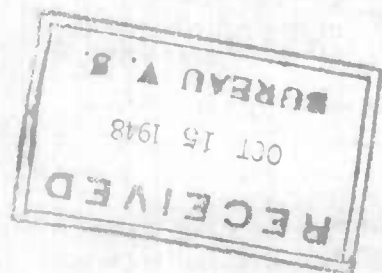
Address..... Hagerstown Md. Date signed..... 10/22/48

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:
930 Spruce Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 930 Spruce Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Susan Richardson

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

8. (b) Name of husband or wife... Willaim M. Richardson

7. Birth date of deceased (mo., day, yr.) October 27, 1852

8. AGE: Years 95 Months 11 Days 27 If less than one day
hrs. min.9. Birthplace... Franklin County, Pa.
(Town, county, and state)

10. Usual occupation... Home Duties

11. Industry or business

12. Name... Hezekiah Luckett

13. Birthplace... Frederick Co., Md.

14. Maiden name... Elizabeth Koons

15. Birthplace... Frederick, Co., Md.

16. Informant... Howard E. Gossard

Address 930 Spruce St- Hagerstown, Md.

17. Burial Date thereof Oct. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Norland Cemetery

Location... Chambersburg, Pa.

18. Funeral director... Fred W. Kraiss

Address... Hagerstown, Md.

19. Oct. 26, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 23, 1948 2:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-48 to 10/23/48
and that I last saw him alive on 10-23-48

Immediate cause of death... Congestive Heart Failure

DURATION

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

23. SIGNATURE... Hagerstown, Md.

Address... Hagerstown, Md.

Date signed 10/23/48

10848

93d

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10849

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one week

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? one week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Rural- Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Huettis-Hagerstown RFD#2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Milton Porterfield Ridenour, Milton Porterfield

3. (b) Social Security Number

232-26 6900

4. Sex

Male M

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Edith Pearl Ridenour7. Birth date of deceased (mo., day, yr.) Dec. 4, 18866.(c) If alive, give age 58 years8. AGE: Years Months Days If less than one day
61 9 27 hrs. min.9. Birthplace Halfway, Wash., Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Benjamin Ridenour13. Birthplace Washington Co., Md.14. Maiden name Jennie Weller15. Birthplace Washington Co., Md.16. Informant Mrs. Edith Pearl RidenourAddress Hagerstown, Md. RFD#217. Burial Date thereof Oct. 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress Williamsport, Md.19. Oct. 2, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 1, 1948 19 48 at 8:24 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
AUGUST 11, 1946 19 48 to OCTOBER 1, 1948
and that I last saw him alive on OCTOBER 1, 1948Immediate cause of death
CEREBRAL HEMORRHAGE DURATION 48 HRS.Due to HYPERTENSIVE CARDIO VASCULAR
RENAL DISEASE ?
DXX UREMIA 5 DAYS

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

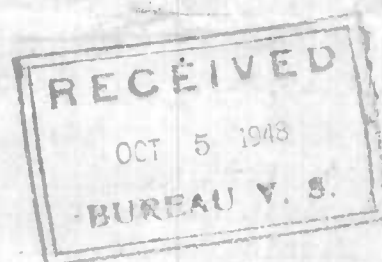
23. SIGNATURE Arthur Robert Cohen M. D.Address Clear Spring End Date signed 10-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Yeager

10850

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 Years
 Hospital, institution, or street address where death occurred:
119 King St./
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 119 King St.
 (If rural, give LOCATION)
 2.(a) Is veteran, name war None

3. (a) FULL NAME

MRS ELLA FUNK BOVEY

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife George H.
 6. (c) If alive, give age -- years
 7. Birth date of deceased (mo., day, yr.) November 1 1852
 8. AGE: Years 95 Months 11 Days 3 If less than one day -- hrs. -- min.

9. Birthplace Beaver creek Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name Andrew N. Funk
 13. Birthplace Beaver Creek Md.
 14. Maiden name Catherine Boub
 15. Birthplace Beaver Creek Md.

16. Informant Mrs. Brayden Ridenour
 Address Hagerstown Md.

17. Burial 10/6/48
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funerary director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct 6. 48 Pharrell Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Noon

20. DATE OF DEATH October 4 1948 19 48 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20. 19 48 to Oct. 4. 19 48
 and that I last saw him alive on Oct. 4. 19 48

Immediate cause of death Arteriosclerosis
Acute Cardiac Failure
Chronic Pulmonary Emphysema
 Due to 11 yrs.
12 hours.
 Due to Senility.
 Other conditions Senility.
 (Include pregnancy within 3 months of death)

Major findings of operations -- Date of op. --

Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide X X X X Date of --
 Where did injury occur? X X X X (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) --
 Means of injury -- Injured at work? --

23. SIGNATURE W. Howard Yeager M. D. or other --
Hagerstown Md. Date signed 10-5-48
 Address --

RECEIVED

OCT 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10851

1220

302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
45 West North Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 45 West North Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Roy Scott (Roy Scott)

3. (b) Social Security Number

219-05-2675

4. Sex

Male

5. Color or Race

Colored

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Maggie Scott

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

February 19, 1886

8. AGE:

Years

62

Months

7

Days

22

It less than one day

hrs.

min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name John Scott13. Birthplace Buckeystown, Maryland14. Maiden name Harriet Bird15. Birthplace Hagerstown, Maryland16. Informant James ScottAddress Hagerstown, Maryland17. BurialDate thereof 10-15-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director William H. DowneyAddress Hagerstown, Maryland19. Oct. 15, 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION About20. DATE OF DEATH Oct. 12 19 48 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

acute intestinal obstructionDue to (strangulated/inf) inguinal
hernia)Due to ShockOther conditions chr. ~~xxx~~ alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date ofWhere did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE S. P. Wells DEPUTY MEDICAL EXAM.
Hagerstown, Md. WASH. CO., MD.
Address Date signed Oct 13, 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. ditto

10852

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 days
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Moller Apts
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war

3. (a) FULL NAME

CLARENCE HUGHES SHULL

3. (b) Social Security Number

719-05-6314

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white widower

6. (b) Name of husband or wife

Alice Fuller

7. Birth date of deceased (mo., day, yr.)

September 18 1872

8. AGE: Years Months Days If less than one day

76 1 9 hrs. min.

9. Birthplace

Woodstock Shenandoah Co. Va.
(Town, county, and state)

10. Usual occupation

R. R. Engineer

11. Industry or business

Retired

12. Name

William Shull

13. Birthplace

Winchester Va.

14. Maiden name

Frances Dean

15. Birthplace

Winchester Va.

16. Informant

Mrs. Frances Slifer

Address

Hagerstown Md.

17. Burial Date thereof

Date thereof 10/29/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19. Oct. 28 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 27 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 - 48 to Oct 27 - 48

and that I last saw him alive on Oct 27 - 48

Immediate cause of death

Ch. Myocarditis

Due to

Ch. Myocarditis

Due to

Bronch. Pneumonia

Other conditions

Thrombosis

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed



RECEIVED

OCT 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10854 302

1. PLACE OF DEATH:

County.....**Washington**
 City or town.....**Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....**42 years**
 Hospital, institution, or street address where death occurred:
916 Mulberry Ave.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....**Md.** County.....**Washington**
 City or town.....**Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....**916 Mulberry Ave.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Hollis Edward Snapp

3. (b) Social Security Number

214-09-5873

4. Sex.....**male**
 5. Color or race.....**white**
 6.(a) Single, married, widowed, or divorced.....**married**
 6.(b) Name of husband or wife.....**Dora Snapp**
 6.(c) If alive, give age.....**58** years
 7. Birth date of deceased (mo., day, yr.).....**February 19, 1880**
 8. AGE: Years.....**68** Months.....**7** Days.....**20**
 If less than one day..... hrs. min.

9. Birthplace.....**Hayfield, Frederick Co. Virginia**
 (Town, county, and state)
 10. Usual occupation.....**Carpenter**
 11. Industry or business.....**Jamison Cold Storage Dorr Co**
 FATHER
 12. Name.....**John Snap**
 13. Birthplace.....**Frederick Co., Va.**
 MOTHER
 14. Maiden name.....**Alice Larrick**
 15. Birthplace.....**Frederick Co., Va.**

16. Informant.....**Kenneth Snapp**
 Address.....**Hagerstown, Md.**
 17. **burial** Date thereof.....**10-12-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....**Rose Hill Cemetery**
 Location.....**Hagerstown, Md.**
 18. Funeral director.....**Scott F. Minnich & Son**
 Address.....**Hagerstown, Md.**

19. **Oct. 12, 48** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**Oct 9**.....**48**.....**11:30 A.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 10.....**48**.....to.....**Oct 9**.....**48**
 and that I last saw him alive on.....**Oct 8**.....**48**

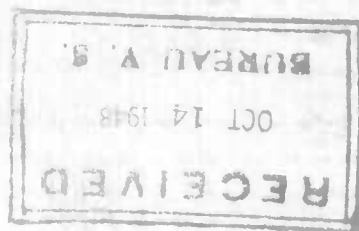
Immediate cause of death.....**Coronary Thrombosis**
 DURATION.....**10/9/48**
 Due to.....**arteriosclerosis**
Hypertension
 Due to.....
 Other conditions.....
 (include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....**H. H. Porterfield M.D.**
 M. D. or other.....
 Address.....**136 W Washington**..... Date signed.....**10/14/48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10855 306

1. PLACE OF DEATH:

County... WashingtonCity or town... Cascadia

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 25 days

Hospital, institution, or street address where death occurred

Ritchie HospitalHow long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... MontgomeryCity or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Lacus Lane

(If rural, give LOCATION)

2.(a) If veteran, name war ☒

3. (a) FULL NAME

Etta May Stottmeyer

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 25, 1865 -

8. AGE: Years Months Days If less than one day

83 4 22 hrs. min.

9. Birthplace

Wellsville, Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

Eliza R. Stottmeyer

13. Birthplace

Wellsville, Md.

14. Maiden name

Eliza Hoover

15. Birthplace

Hosp. records.

16. Informant

Address Camp Ritchie, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 20, 1948

(month) (day) (year)

Cemetery or crematory

Smithsburg Cemetery

Location

Smithsburg, Md.

18. Funeral director

Address Edith V. LeafWilliamsport, Md.19. Oct. 18 19 48 Geo. W. Ferguson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 19 48 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 19 48 to Oct 17 19 48and that I last saw him alive on Oct 17 19 48

Immediate cause of death

Cerebral Hemorrhage 2 1/2 hrs.

Due to

Cerebral Arteriosclerosis

Due to

Cerebral thrombosis (?)

Other conditions

old rt hemiplegia.

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J.M. Cunningham, M.D.Address Ritchie Hosp. Date signed 10/17/48Smithsburg, Md.

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

RECEIVED

OCT 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10856 306

1. PLACE OF DEATH:

County Washington
 City or town Cascade
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One year 9 days
 Hospital, institution, or street address where death occurred:
Ritchie Hospital
 How long in hospital or institution? Same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2632 Penna Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Joanna Hines
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Sept 17, 1872
 8. AGE: Years 76 Month 1 Days 6 If less than one day hrs. min.

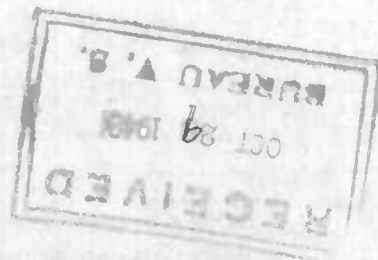
9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Unknown
 11. Industry or business
 12. Name John Teal
 13. Birthplace
 14. Maiden name
 15. Birthplace

16. Informant Hosp. records
 Address
 17. Burial Date thereof Oct 26-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Golden Crest Cem
 Location Baltimore Md
 18. Funeral director M. L. Greer Day
 Address Thurmont Md
 19. Oct 26 1948 Geo. W. Ferguson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948 at 4:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Oct 23 1948
 and that I last saw him alive on Oct 23 1948
 Immediate cause of death Broncho pneumonia DURATION 48 hrs
 Due to
 Due to
 Other conditions Atherosclerosis & Hemiplegia & Dementia ?
 (Include pregnancy within 8 months of death)
 Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE J. M. Armstrong, M.D.
 Address Ritchie Hosp. Baltimore, Md. Date signed 10/23/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 Years
 Hospital, institution, or street address where death occurred:
715 N. Locust St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 715 N. Locust St.
 (If rural, give LOCATION)
 2. (a) If veteran, same war

3. (a) FULL NAME

Annie A. Tetlow

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Robert Tetlow
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 9, 18 53
 8. AGE: Years 95 Months 04 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co. Md.
 (Town, county, and state)
 10. Usual occupation Home duties
 11. Industry or business
 12. Name Emanuel Stauffer
 13. Birthplace Maryland
 14. Maiden name Mary Hill
 15. Birthplace Maryland

16. Informant Mrs. Ruth Sayles
 Address 715 N. Locust St. Hagerstown, Md
 17. Burial Date thereof Oct. 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Fairview Cemetery
 Location Keedysville, Maryland
 18. Funeral director Wred W. Kraiss
 Address Hagerstown, Maryland

19. Oct. 21, 1948 Registrar Phas H. Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1948 19 48 at 4:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1948 to Oct. 19, 1948
 and that I last saw him alive on October 18, 1948

Immediate cause of death Chronic myocarditis DURATION ?
 Due to _____
 Due to _____
 Other conditions Arteriosclerosis DURATION ?
 (Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op. _____
 Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Ra Bee M. D. or other _____
 Address Hagerstown Md. Date signed 10/19/48

RECEIVED

OCT 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10858

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
717 North Locust Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 717 North Locust Street
 (If rural, give LOCATION)
 2.(a) If veteran, name and number.....

3. (a) FULL NAME

Anna E. Thomas

3. (b) Social Security Number

NONE

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, or divorced..... Married
 6.(b) Name of husband or wife..... Charles W. Thomas
 6.(c) If alive, give age..... 77 years
 7. Birth date of decedent (mo., day, yr.)..... February 2, 1881
 8. AGE: Years..... 67 Months..... 8 Days..... 12 If less than one day..... hr. min.

9. Birthplace..... Bridgeport, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....
 12. Name..... George Betts
 13. Birthplace..... Hagerstown, Maryland
 14. Maiden name..... Florence C. Howr
 15. Birthplace..... Hagerstown, Maryland
 16. Informant..... Charles W. Thomas
 Address..... Hagerstown, Maryland
 17. Burial..... Burial Date thereof..... 10-17-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rest Haven Cemetery
 Location..... Hagerstown, Maryland
 18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Oct. 16, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 14, 1948 at 7 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended decedent from
Sept/3/1940 to Oct/12/48
 and that I met with..... alive on.....
 Immediate cause of death.....
chr. myocarditis
 Due to.....
acute pulmonary embolus
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... None Date of op.....
 Autopsy results..... no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... No Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... S. Robert Wells, M.D.
Hagerstown, Md. Date signed..... 10/15/48
 M. D. another



Address Hagerstown, Md Date signed 10/18/93

PLEASE WRITE PLAINLY, WITH ~~NON~~FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. —

RECEIVED

OCT 21 1938

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto 10860

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Fairview
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 30 Years
 Hospital, institution, or street address where death occurred:
Fairview
 How long in hospital or institution?..... 30 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Fairview
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... None
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3.(a) FULL NAME

Charles Wiles

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Jenne

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Oct. 9 1866

8. AGE:

Years

Months

Days

If less than one day

82013

hrs.

min.

9. Birthplace

Williamsport Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

Trucker

11. Industry or business

Retired

MOTHER FATHER

12. Name

Jacob Wiles

13. Birthplace

Germany

14. Maiden name

Louisa Schmidt

15. Birthplace

Germany

16. Informant

William Wiles

Address

Wilson, Maryland

17.

Burial

Date thereof

Oct. 30, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Church Of God Cemetery

Location

Broadfording, Md

18. Funeral director

Andrew K. Coffman

Address

Hagerstown, Md.

19.

Oct. 30, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 24-48 19..... at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 28-48 19..... to Oct 28-48 19.....
and that I last saw him..... before Oct 28-48 19.....

Immediate cause of death.....

DURATION

Cardio Vascular Disease 6 hrs
 Due to.....
Dead after arrival
possibly 4 days
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

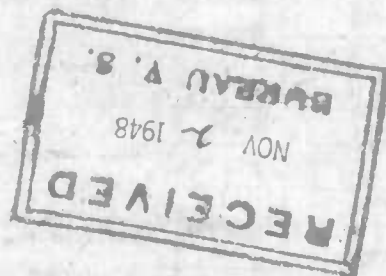
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



Dr. R. A. Beebe

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Dunkstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 years
 Hospital, institution, or street address where death occurred:
Antietam and maple st.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Dunkstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Antietam and maple st.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

3. (b) Social Security Number

Ida Mae Williams

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife R. Glenn Williams
 7. Birth date of deceased (mo., day, yr.) October - 31 - 1882
 6. (c) If alive, give age years
 8. AGE: Years 65 Months 11 Days 29 It less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 2:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17, 1948 to Oct. 29, 1948
 and that I last saw her alive on October 29, 1948

Immediate cause of death Bronchiectasis
Terminal Bronchopneumonia

DURATION

3 years

Due to None
 Due to None

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. A. Beebe M. D. or other

Address Dunkstown Md. Date signed 10/30/48

9. Birthplace Jefferson Fred. Co. Md.
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business own home
 12. Name Martin Alexander
 13. Birthplace Jefferson Fred. Co. Md.
 14. Maiden name Mary Ellen Stockman
 15. Birthplace Jefferson Fred. Co. Md.
 16. Informant R. Glenn Williams
 Address Dunkstown Md.
 17. Burial Burial Date thereof Nov. 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Dunkstown Cemetery
 Location Dunkstown Md.
 18. Funeral director Wm. J. Bast & Sons
 Address Baltimore Md.
 19. Nov. 1, 48 Registrar Chas. H. Bowers
 (Date rec'd by registrar)

RECEIVED
NOV 8 1948
BUREAU A. B.